

Minutes

Advisory Panel on Medicare Education (APME)

May 12, 2000

Location:

The meeting was held at the Phoenix Park Hotel, 520 North Capitol Street, NW, Washington, DC. The meeting was announced in the *Federal Register* for April 27, 2000 (Volume 65, Number 82, Pages 24707-24708) (Attachment A).

PRESENT

Panel Members:

Diane Archer, Medicare Rights Center
Bruce Bradley, General Motors Corporation
Joyce Dubow, AARP
Elmer Huerta, Washington Hospital Center
Bonita Kallestad, Mid Minnesota Legal Assistance
Steven Larsen, Maryland Insurance Administration
Brian Lindberg, Consumer Coalition for Quality Health Care
Heidi Margulis, Humana, Inc.
Patricia Neuman, The Henry J. Kaiser Family Foundation
Elena Rios, National Hispanic Medical Association
Samuel Simmons, National Caucus and Center on Black Aged, Inc.
Edward Zesk, Aging 2000

Chair:

Carol Cronin, HCFA

Executive Director:

Susana Perry, HCFA

ABSENT:

Nina M. Weinberg, National Health Council

Invited Guest:

Melane Kinney Hoffman, National Health Council

A "sign in" sheet listing other attendees is incorporated as Attachment B.

Summary:

Susana Perry, Executive Director, opened the meeting. Carol Cronin, Panel Chair and Director of the Center for Beneficiary Services at HCFA discussed consumer information on quality as the focus. Several quality experts addressed the Panel.

John M. Eisenberg, M.D., Administrator of the Agency for Healthcare Research & Quality (AHRQ), provided an overview about quality measurement efforts, report cards, challenges in quality improvement and the Federal role in quality. Dr. Eisenberg discussed three uses of quality information: improvement, regulation and choice. He also spoke of international efforts to deliver better care through better information, and steps involved in providing quality care to consumers. Dr. Eisenberg cited underuse, overuse and misuse of care as problems related to providing quality care. Structure, process and outcome were discussed as elements of quality measurement, and equity, efficiency and choice were cited as underlying evidenced-based policy principles (Attachment C).

Scott C. Ratzan, M.D., Executive Director, Health Communication Technology and Educational Innovations, Academy for Educational Development and Editor-In-Chief, *Journal of Health Communications* provided ideas for how to get consumers to care about quality from a social marketing perspective. The presentation began with a model of the 21st century path to quality health and the current understanding of disease. The definition of health, its attainment and development were presented. Using the World Health Organization's definition of quality, Dr. Ratzan suggested quality health communication techniques and models, and factors contributing to health. He discussed science-based approaches to quality health care development, and methods of influencing consumer behavior. He also introduced a new field model outlining determinants of health, disease prevention strategies and theoretical frameworks for development of health indicators, and a model of policy formation.

Dr. Ratzan described social marketing concepts including segmentation techniques, lifestyle and demographic characteristics, and discussed negotiation between stakeholders and partnerships as an effort to find best solutions to policy issues. He offered a description of attitudes and current practices, and posed questions to the panel regarding the current status of quality health care information and its dissemination. Strategies for better health care through better communication were discussed. Dr. Ratzan also spoke of the potential for improving communication through use of technology, and barriers to quality health care. Finally public health and media objectives were presented in an effort to develop a path to quality health (Attachment D).

Jeffrey Kang, M.D., Director of the Office of Clinical Standards and Quality and Chief Clinical Officer at HCFA briefed the Panel on HCFA's quality agenda, current research and future plans (Attachment E). Dr. Kang discussed key requirements for conditions of participation by plans and providers and "blaming" versus "learning" approaches to quality improvement. The role of the peer review process in quality improvement was

highlighted. Statistics were provided on the rate of patients prescribed beta-blockers on hospital discharge, variations in their use, baseline quality indicator rates, and changes in quality indicator rates. National quality improvement projects were listed, as were characteristics of measurement for accountability. Dr. Kang emphasized the importance of consumer information and consumer choice. Public reporting of quality measures were stated. The presentation ended with issues regarding release of plan or provider performance measures.

Robert Berenson, M.D., Director of HCFA's Center for Health Plans and Providers discussed how to communicate quality through health plans and providers. He spoke of ideas for modernizing the program, building value-based purchasing, and rewarding quality.

Dr. Berenson noted that Medicare+Choice plans are having trouble gaining a reputation for quality. He sees risk adjustment as the problem, and feels that without risk adjustment, those plans doing the best job of providing quality care are fundamentally penalized. Dr. Berenson said that Medicare+Choice plans want to avoid having the reputation of being the best at providing services for specific health issues because they will then attract the patients with that health challenge. He also spoke of demonstration projects to modernize fee-for-service Medicare by establishing and enforcing standards, and giving doctors, plans and providers technical assistance. Within these demonstrations, HCFA can reward performance, change the payment system, help a hospital gain recognition as a center that HCFA has designated, and provide some financial incentives for beneficiaries to use those plans and hospitals.

Thomas Reilly, Ph.D., Director of the Division of Beneficiary Analysis gave an update on HCFA's current efforts to communicate quality and satisfaction information to consumers in the areas of Medicare managed care plans, nursing homes, and other health care providers (Attachment F). Dr. Reilly outlined the process of reporting quality information for Medicare health plans. He also spoke of the extensive Medicare Health Plan Compare information, which is available on the www.medicare.gov web site.

The meeting had several periods of open discussion by the Panel including general comments on quality, along with specific reactions and feedback on areas HCFA outlined. The following is a summary of key topics discussed during the meeting.

General Comments:

Panel members responded positively to HCFA's overview of its current activities relating to quality. Many said that HCFA's quality agenda is moving in the right direction. One member applauded HCFA for including Hispanic issues regarding nursing home quality of care.

Nursing Home Compare Feedback:

Nursing Home Compare, a feature on the www.medicare.gov website, also received positive comments.

The Committee expressed interest in how Nursing Home Compare is being publicized. They felt that showing the information (with disclaimers) helps move nursing homes toward improvement and accountability (for example, toward a reduction of bed sore incidents). They view the site as an important tool for information intermediaries who could use it to help solve a multitude of problems.

One member thought the website contained more disclaimers than necessary, implying that HCFA has the data and wants to use it, but is not committed to what the data may indicate to consumers. Carol Cronin, Committee Chair, pointed out that HCFA felt the need to use disclaimers because the data is self-reported.

The question was raised as to whether HCFA collects racial and minority data to be posted on the Nursing Home Compare website. Dr. Thomas Reilly of HCFA confirmed that HCFA collects such data, but privacy issues may prevent HCFA from using it. Dr. Reilly will explore the issue further and report back to the Panel at a future date.

Affordability and Access Before Quality:

Panel members agreed that access to the health care system with affordable coverage is an important concern of most Medicare consumers. Quality is often a secondary concern of consumers, because many consumers must make choices based upon cost. The Panel discussed how Congressional cuts in Medicare expenditures have shifted more costs to the consumer. Panelists agreed that standardization, affordability and value need to be included in the quality equation.

Members mentioned the need to have standardized, simple systems that make it easier for patients. Current legislative proposals in Congress allow every plan the flexibility of having different systems.

Consideration for Vulnerable Subpopulations:

It was suggested that outreach to vulnerable populations about quality issues should have priority over outreach to well educated Medicare consumers. Throughout the meeting panelists suggested that any strategy to address quality should also address the needs of vulnerable populations.

Panelists believe that part of the Medicare population is not able to make use of comparative information. One panelist sees a great need to segment the population, citing that if a large percentage cannot use comparative information, the use of comparative data may not be a viable strategy for informing or educating consumers.

Motivating People to Care About Quality:

Panelists agreed that moving the marketplace toward quality is movement in the right direction. However, they repeatedly mentioned the challenge of getting consumers to care about and understand quality along with how to get the system to work better for vulnerable populations. Barriers were mentioned, such as how to effectively convey complex concepts regarding quality measures, lack of standardized quality information / ratings, and lack of a compelling message for people to easily understand why they should care about quality.

Panelists suggested using the Medicare lock-in period, which begins January 2002, as an opportunity to help Medicare consumers understand why they should care about quality. Because they will have to stay in the health plan for a year, it is important for Medicare consumers to take time to evaluate the quality of different health plans. Panelists also believe that the public assumes health care quality is acceptable when it is not. The Panel wants HCFA to do a better job of educating the public about where health care is variable; for example, medical errors.

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Developing a Compelling, Yet Simple Quality Message:

Panelists expressed a need for a simple solution to communicate quality in health care. They suggested exploring how other industries convey quality ratings to gain more insight. The hotel industry's method of conveying quality information was suggested as a possible option for conveying quality information to Medicare consumers—where 3 or 4 stars symbolize quality. Others felt this was an oversimplification of a very complex issue and discouraged its use.

Several Panel members struggled with the need to convey a simple message to the media and what the message should be regarding quality in general. The 2001 Medicare enrollment lock-in was again seen as the potential media hook or angle for optimum successful outreach efforts.

One member said that we need global, broad messages regarding quality and suggested HCFA give Medicare consumers some guidelines to enable them to judge whether they are getting good quality health care, thus bringing the message down to a personal level. The major difficulty identified was translating quality measures into something actionable.

Harnessing the Media and Social Marketing:

Panelists expressed a need to harness the media to focus on quality. Using non-traditional media sources, such as Hollywood movies and soap operas, was suggested to convey social messages. They requested that HCFA's social marketing contractor be involved in upcoming meetings to further discuss this approach.

Use of the negative message to grab attention was widely discussed. Panelists deliberated whether pursuing negative messages is the correct way to proceed. One member commented that broadcasting negative messages requires a continual raising of the bar to gain attention, which won't work for long-term change.

The Panel proposed that HCFA develop a strategy to target minority radio and television. To support that view, a panelist cited the success of various national organizations in reaching Hispanic and African American populations through the use of audio news releases (ANRs) produced in a gospel, blues, urban or contemporary format.

Panelists noted that successful behavior change occurs slowly and over time. Examples of successful campaigns are the National Heart, Lung, and Blood Institute's (NHLBI's) blood pressure monitoring campaign and the national seat belt campaign.

Expanding Regional Information Intermediaries to Include Quality:

The need to expand funding to information intermediaries, such as State Health Insurance Assistance Programs (SHIPs) was discussed, and panelists pointed out regional market differences and dynamics.

More funding and better utilization of SHIPs was a suggestion to more effectively convey information to Medicare consumers. Other information intermediaries were seen as overburdened and less knowledgeable than SHIPs. Panelists felt that HCFA was not asking for enough funding or training for SHIPs, and recommended that the program be strengthened and better funded. Panelists were interested in understanding the actual extent of the SHIP network, and whether SHIPs have a national quality message that is part of the dialogue they use to educate Medicare consumers.

Panelists expressed interest in collectively writing a report to Congress, recommending increased funding and support for SHIPS and in other necessary measures to help Medicare consumers make informed choices.

One panelist suggested the report focus on macro-issues surrounding health literacy and whether there should be more money for one-on-one counseling. Another suggestion was to explore regional models of information and education distribution, or HCFA could emulate the Social Security Administration's model of district offices for a more visible, local approach.

Releasing Composite Measures vs. Individual Measures:

A member asked whether HCFA is planning to provide composite measures in future communications to patients (i.e. the implications for not getting eye exams for diabetics). HCFA is beginning to work with composite measures. The Chair asked the Panel whether they think HCFA should be moving in that direction, because this is an important issue that has not been explored. There is little research on how to measure the care given to diabetics across multiple measurements, and then aggregate these measures into a

summary score that could be given to beneficiaries in the context either of a choice situation, or even in the context of a discussion between a doctor and a patient about diabetic care.

HCFA staff asked whether it was more advisable to create and release composite measures rather than individual measures. If individual measures are advisable, should HCFA create or endorse specific decision tools? Is the public's right to know more important than ensuring the accuracy of the data? Should HCFA require public information be audited first?

Several panelists responded that accuracy is of utmost importance for the elderly population, saying that if the information is not accurate and understandable, then it is of no use. Members were concerned that HCFA would prematurely release composite data, in effect "dummying down" or obscuring the information.

Panelists expressed concern that HCFA's release of composite scores could allow weak areas to be covered up or ignored. Sharing hospital rates could help patients have a dialogue with their physician, giving them questions to ask and a common language through which to communicate. A panelist said it is important to tell consumers how things work, how they might work, and how they are actually working. One member cited a need to ensure the quality of care that patients receive meets minimum standards; otherwise the entire burden is placed on the consumer. A request was also made for *Consumer Assessment of Health Plans* (CAHPS) survey data to be easily accessible or published.

A panelist pointed out that health plans are not intentionally providing low quality care. Rather, the industry is subject to more performance measurement than other industries, and as such, has more benchmarks against which it needs to work. HCFA has made progress, and health plans provide better care as a result. Panelists suggested that the government help plans identify and motivate physicians and patients to participate in disease management programs. Plans have problems getting patients to remain in these programs and getting physicians to participate in them.

The Panel requested information about the accuracy and validity of the fee-for-service and Medicare+Choice data. Some Medicare consumers move from Medicare+Choice plan to Medicare+Choice plan. The question was raised about data on people who have remained in plans over a length of time. There was strong interest in knowing what was being measured in fee-for-service versus Medicare+Choice.

Other General Comments on Quality:

A common message throughout the meeting was the importance of disseminating very basic information at the state level, even though each state has special rights and protections for its citizens. The Chair suggested that more information be provided on cost, then perhaps the Panel could look beyond that to quality improvement.

One member asked about developing relationships around the nation with opinion leaders, and suggested developing a national effort to build a training session for opinion leaders.

Panelists recommended targeting children of Medicare consumers to help inform and educate their parents, but panelists warned against patronizing Medicare consumers who are capable of making decisions for themselves. Another suggestion was to teach people about reliable sources, how to look for information that is properly vetted, and to look at improving both individual and population-based quality improvement.

Although quality information in the *Medicare & You Handbook* was not widely used, panelists suggested it continue to be included because of its importance, citing the need for consumers to turn to HCFA and Medicare for accurate Medicare information.

There was also some discussion of using private sector models, offering Medicare consumers financial incentives to choose quality health plans.

Members suggested that the view of quality be expanded to include educating people that quality begins with choice. After choosing a plan and provider, Medicare consumers can take steps to ensure continued quality care. Panelists suggested inviting Medicare consumers to be part of the process of creating quality health care. "Get people to understand that they need to be healthy. Even though they're chronically ill, even though they're elderly, there's a certain amount of information that nobody ever gets about how to be healthy, how to live a quality life, healthy to the degree that you can be healthy. It's never too late to start changing behavior."

A panelist questioned whether consumers understand the components of Medigap Compare, and wanted to know the consumers' response to the research. HCFA has 1-800 telephone numbers for almost all of the Medigap insurers in the country. They have some level of information: in terms of type of plans, which of the 10 standardized plans they offer, how they do their rating, and whether they offer it to the under-65 and ESRD populations for approximately 5 to 10 percent of all plans. Much work remains to be done in terms of trying to get that information posted on the www.medicare.gov website.

Public Comment:

A written comment was submitted by Nancy McFall, Government Affairs Specialist of the Social Policy Department of Metropolitan Family Services in Chicago, Illinois. The comments consisted of a written report on efforts by the Metropolitan Family Services of Chicago, Illinois to develop educational materials which explain recent changes to the Medicare program.

Copies were made available to the panel, the general public, and were also made a permanent part of the record.

Future Plans:

Over time the Panel plans to continue discussions about rolling up measures, how quality relates to special populations, how to improve any existing Medicare tools or publications (which requires a one-year lead time), and will further discuss social marketing. Future quality discussions will be broadened to include informed choice and value. Interest was expressed in working with HCFA's social marketing firm to get them involved with the Panel's ideas.

Next Steps:

The next APME meeting will focus on issues involving minority populations. Possible dates for the next meeting will be in September 14 and 15, or September 21 and 22.

Michael McMullan
Acting Director,
Center for Beneficiary Services
Susana Perry
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Advisory Panel on Medicare Education

Enclosures